

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391

APR 11 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2012
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NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME-ALBEMARLE	STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001
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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer the Clonidine as ordered for 1 (Resident #24) of 10 sampled residents reviewed for unnecessary medications . The findings include:</p> <p>Resident #24 was admitted to the facility on 01/22/12 with multiple diagnoses including Hypertension and Chronic Kidney Disease. The Minimum Data Set (MDS) assessment dated 01/31/12 indicated that Resident #24 had moderate cognitive impairment.</p> <p>The physician's orders were reviewed. Resident #24 had a doctor's order dated 01/30/12 to check the blood pressure twice a day and to give Clonidine (antihypertensive medication) 0.1 mgs (milligram) 1 tablet by mouth twice a day if the systolic blood pressure was more than 170. These orders were transcribed to the MARs.</p> <p>The vital sign records and the Medication Administration Records (MARs) for February and March, 2012 were reviewed. Resident #24 did not receive Clonidine in February (thirteen times) and in March (four times) for systolic blood pressure of more than 170. The blood pressure readings and the dates were:</p> <p>February 1 (PM shift) - 185/73</p>	F 281	<p>Preparation and execution of this plan of correction does not constitute agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by Federal and State law.</p> <p>F-281 See attached POC</p>	4/12/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Priscilla Vint</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/6/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>February 2 (PM shift) - 196/96 February 5 (AM shift) - 180/86 (PM shift) - 200/86 February 9 (AM shift) - 184/80 (PM shift) - 178/72 February 10 (PM shift) - 180/75 February 11 (PM shift) - 176/68 February 14, (PM shift) - 208/87 February 16 (PM shift) - 180/80 February 18 (PM shift) - 195/88 February 23 (PM shift) - 195/83 February 26 (AM shift) - 184/71 March 2 (AM shift) - 193/67 March 4 (AM shift) - 173/72 March 7 (PM shift) - 204/88 March 13 (AM shift) - 180/53</p> <p>On 03/14/12 at 3:38 PM, Medication Aide #1 (Med Aide) was interviewed. She stated that she was the Med Aide for Resident #24 on March 7. She acknowledged that she had checked and recorded the blood pressure for Resident #24 on that day. She indicated that she was not aware that there was an order to give Clonidine if the systolic blood pressure was more than 170.</p> <p>On 03/14/12 at 5:55 PM, administrative staff #1 was interviewed. She stated that a few hours ago she was made aware that Resident #24 was not getting the Clonidine as ordered. She checked the MARs and found out that the staff had missed to administer the Clonidine as ordered for Resident #24 several times. She indicated that she had already discussed it with the Med Aides and the Nurse supervisors. She also stated that Med Aides should inform the nurse supervisor when a resident needs a PRN (as needed) medication. She also indicated that the nurse</p>	F 281			

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F 281	Continued From page 2 supervisor should be checking the MARs to make sure the Med Aides did not miss to administer any medications. On 03/15/12 at 8:10 AM, Med Aide #2 was interviewed. She stated that she was the Med Aide for Resident #24 on March 2. She acknowledged that she should have informed the nurse supervisor of the blood pressure of 193/67 but she did not. She also indicated that she did not give the Clonidine as ordered. On 03/15/12 at 8:15 AM, Nurse Supervisor #1 was interviewed. He stated that on 03/14/12 he was made aware that Resident #24 was not getting the Clonidine as ordered. He acknowledged that he missed to instruct the Med Aide to administer the Clonidine when the blood pressure was more than 170. He stated that the Med Aide had provided him a copy of the blood pressure readings everyday but he failed to review them. He also added that Resident #24 had episodes of elevated blood pressure and the attending physician was aware. He stated that Resident #24 did not show any signs of headache, chest pain, dizziness or shortness of breath when her blood pressure readings were elevated.	F 281			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315	F-315 See attached POC	4/12/12	

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F 315	<p>Continued From page 3</p> <p>treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to secure the indwelling catheter tubing to prevent catheter removal or tissue injury from dislodging the catheter for two (2) (Residents # 36 and Resident # 126) of two (2) sampled residents with indwelling catheters. The findings include:</p> <p>1. Resident # 36 was admitted to the facility 4/14/10 and readmitted to the facility 12/30/11 following hospitalization for urinary tract infection. Cumulative diagnoses included: chronic kidney disease, urethral stricture and hypertrophy of the prostate without urinary obstruction.</p> <p>An annual Minimum Data Set (MDS) dated 1/04/12 indicated Resident # 36 had mild cognitive impairment. He was totally dependent on staff for all activities of daily living (ADL) care. The use of an indwelling catheter was indicated on the MDS.</p> <p>The Care Area Assessment for urinary status dated 1/11/12 indicated Resident # 36 had benign prostatic hypertrophy and congestive heart failure. Resident #36 required the use of the indwelling catheter and had an indwelling catheter on admission.</p> <p>A care plan dated 1/11/12 indicated Resident #36 was at risk for urinary tract infection due to the</p>	F 315			

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F 315	<p>Continued From page 4</p> <p>use of an indwelling catheter due to renal failure. Interventions included: catheter care daily and as needed. Change urinary catheter as ordered. Keep urine bag below bladder level. Securement of the catheter was not included on the care plan.</p> <p>On 3/13/12 at 3:55 PM., NA #1 was observed providing catheter care for Resident # 36. The catheter bag was attached to the left side of the bed on the bed frame. The urinary catheter tubing was not anchored in place on the resident. During the catheter care, Resident #36 was turned from side to side two times with the catheter tubing unanchored. On completion of care, NA #1 secured the catheter bag back to the bed frame. The catheter tubing was not secured to the resident. NA #1 stated, at one time, Resident #36 used to have another type of catheter bag with a clip and the tubing was clipped to the bed linens. NA #1 stated she had never secured the urinary catheter tubing to Resident #36's leg.</p> <p>On 3/13/12 at 4:49 PM., Administrative staff #1 stated an in-service on catheter care was done upon hire and at least annually. She stated residents with urinary catheters should have a leg strap in place unless their skin is irritated or the resident refuses to have a leg strap. She further indicated the facility policy stated to use a leg strap for urinary catheters and leg straps were available in the facility.</p> <p>On 3/14/12 at 9:35 AM., Administrative staff #2 stated education on catheter care and securement of catheter tubing was reviewed on hire. Licensed nursing staff observed catheter care which included securing the tubing with a leg</p>	F 315			

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F 315	<p>Continued From page 5 strap.</p> <p>2. Resident #126 was admitted to the facility on 1/6/12 with the following diagnosis: urinary retention.</p> <p>On the admission Minimum Data Set (MDS) dated 1/11/12, he was assessed as having a moderate cognitive impairment and using an indwelling Foley catheter. Resident #126 could ambulate independently off the unit and needed limited assistance with bed mobility, personal hygiene and toilet use.</p> <p>A care plan dated 1/23/12 indicated Resident #126 had an altered urine pattern related to diabetes mellitus type II, neuromuscular impairment and urine retention. A goal was set to avoid any urinary complications from the use of an indwelling catheter and the development of an urinary tract infection (UTI). Interventions to be used included: an indwelling catheter, to assess his abdomen for distention, assess him for an UTI, to note characteristics of his urine and to provide catheter care each day and maintain patency of the equipment. In addition, staff would use protective pads as needed, keep the tubing kink free, keep urine drain bag below the bladder level. Securement of the catheter was not included on the care plan.</p> <p>On 3/13/12 at 3:30pm, NA #2 and NA #3 were observed providing catheter care for Resident #126. The catheter was placed through the pajama bottom opening and it was not observed</p>	F 315			

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F 315	Continued From page 6 to be secured to the resident ' s body. Resident #126 indicated that he was sore down there (placement of catheter), as the aides began to clean his penis, as well as turned him from side to side, twice. The aides indicated that his tubing was not anchored with a strap to his leg because he tends to get up by himself and will snatch it out. On 3/13/12 at 4:49 PM., Administrative staff #1 stated an in-service on catheter care was done upon hire and at least annually. She stated residents with urinary catheters should have a leg strap in place unless their skin is irritated or the resident refuses to have a leg strap. She further indicated the facility policy stated to use a leg strap for urinary catheters and leg straps were available in the facility. On 3/14/12 at 9:35 AM., Administrative staff #2 stated education on catheter care and securement of catheter tubing was reviewed on hire. Licensed nursing staff observed catheter care which included securing the tubing with a leg strap.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	F-322 See attached POC	4/12/12

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F 322	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff interviews and record reviews the facility failed to provide care to prevent potential aspiration for 1 of 1 residents with a continuous tube feed (Resident # 64). The findings included.</p> <p>Review of the facility policy titled " Enteral Nutrition " dated 1/26/11 revealed, in part, under the ' Procedures ' heading " 4. Position resident in the semi-fowlers position or higher. Residents receiving continuous tube feeding should be kept in semi-fowlers position at all times. "</p> <p>According to Mosby ' s Medical Dictionary, 8th Edition, 2009, semi-fowlers position was " placement of the patient in an inclined position, with the upper half of the body raised by elevating the head of the bed approximately 30 degrees. "</p> <p>Resident #64 was admitted on 7/23/09 and last readmitted on 3/7/12 with diagnoses including diabetes, hypertension, Gastroesophageal reflux disease, pressure ulcers and hepatic cirrhosis. Resident #64 also had a Gastrostomy Tube (G-tube) inserted in Feburary 2012.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 2/20/12 revealed Resident #64 was cognitively intact and required extensive to total assistance of one to two people for all activities of daily living. She was able to understand but had difficulty communicating as her speech was unclear.</p>	F 322			

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F 322	<p>Continued From page 8</p> <p>On 3/15/12 at 9 AM Nurse #2 was observed doing a pressure ulcer dressing change for Resident # 64 who had a continuous tube feed running. Nursing Assistant #5 was also in the room and assisted to position Resident #64 in bed. During the treatment, Nurse #2 lowered the head of the bed to approximately 10 - 15 degrees while the tube feeding continued to run. Nurse #2 was interviewed and was asked if she ever turned the tube feeding off before she lowered the head of the bed to 10 - 15 degrees to provide wound treatment to Resident #64. She stated that the tube feed never got turned off as it was continuous but she just lowered the head of the bed that much until the treatment was completed.</p> <p>Interview with Nurse #3 on 3/15/12 revealed that she had never been asked to turn the tube feeding pump back on after a staff member had lowered the head of the bed to provide care. She also stated that the head of the bed for Resident #64 was to remain raised and the tube feeding was not turned off as it was continuous.</p> <p>Interview with NA #5 revealed that she had often provided activities of daily living care to Resident #64. She stated that while Resident #64 has had the continuous tube feeding she would lower the head of the bed about the same as Nurse #2 did during the dressing change that morning (10 - 15 degrees) or maybe a little higher (20 degrees). She stated that she never turns off the tube feeding and that the head of the bed for residents with a tube feeding should be 30 degrees or higher.</p> <p>During interview with Administrative Staff #1 on 3/15/12 at 10 AM she stated that the facility did</p>	F 322			

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F 322	<p>Continued From page 9</p> <p>not have a policy or procedure for what to do during care when the head of the bed needed to be lower than 30 degrees for residents on a continuous tube feeding. She stated that if the head of the bed was lowered to 10 - 15 degrees, she thought it would be safe for a brief period. She also indicated that she was aware of the risk of aspiration when the head of the bed was lower than 30 degrees for residents who were being tube fed. Administrative Staff #1 also said that Resident #64 had been tolerating the head of the bed being lowered during care and turning off the tube feeding would require an order as the feeding was continuous.</p> <p>Interview with Administrative Staff #2 revealed that during orientation staff receive general orientation regarding care for residents with tube feedings and that staff are made aware that the head of the bed needs to be 30 degrees or higher. She added that staff receives additional education as new situations arise. Administrative Staff #2 said that in the facility residents are usually only on tube feedings at night and that Resident #64 was the only one they had encountered that was on a continuous tube feeding. She revealed that because of this they had never had to deal with concerns or questions about lowering the head of the bed less than 30 degrees during care. When asked, she was unable to provide any information about any education staff had received for providing care to residents with a continuous tube feeding. She further stated that staff had not asked her about lowering the head of the bed during care but if they had she would have told them it was safe to lower the head of the bed a little during care as long as the resident was tolerating it. When she</p>	F 322			

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F 322	Continued From page 10 was asked what the signs of not tolerating the head of the bed being lower than 30 degrees would be she indicated that regurgitation would be a sign but also acknowledged that regurgitation could lead to aspiration.	F 322			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review the facility failed to ensure interventions were in place to prevent a repeat skin tear injury for 1 of 4 sampled residents (Resident # 23). The Findings included: Resident #23 was admitted on 10/18/11 with diagnoses including dementia and mood disorder. The Annual Minimum Data Set (MDS) assessment dated 9/28/11 revealed Resident # 23 had moderately impaired cognition and required extensive assistance of one person for transfers. Review of the Care Plan updated 10/5/11 revealed " check w/c (wheelchair), Bed/GC (Geri-chair) for sharp edges and pad as needed. "	F 323	F-323 See attached POC	4/12/12	

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F 323	<p>Continued From page 11</p> <p>The incident documentation in the computerized medical record for 11/27/11 revealed that at 11:30 AM, during morning care, the resident "bumped leg on wheelchair (area that connects leg rest)." Resident #23 had a skin tear injury from this incident described in the incident documentation as being on her lower left extremity, 1.5 (unit of measure not indicated) in length and in the shape of a half moon. In the section titled ' Teaching Done ' it indicated that the Nursing Assistant who had been transferring the resident was educated on safe transfer techniques. In the section titled ' Immediate Actions ' it read " padded area that connects legs to wheelchair due to resident does not use leg rests. "</p> <p>Review of the Care Plan updated 11/29/11 revealed " keep w/c (wheelchair) padded at leg rest. "</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 12/21/11 revealed Resident # 23 had moderately impaired cognition and required extensive assistance of one person for transfers.</p> <p>The incident documentation in the computerized medical record for 2/24/12 revealed that at 8:55 PM Resident #23 received a second skin tear from the sharp edge of her wheelchair where the foot rests would attach if she used them. The note indicated that when Resident #23 was asked what happened she said " she cut my leg " , " let me show you, right here on this sharp piece " and that as she said this she was " pointing at the bottom section of her wheelchair to show the nurse where her leg was cut, left side of wheel</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME-ALBEMARLE			STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 12</p> <p>chair where the foot pedals would have been attached." In wound was documented as: " a large skin tear to residents left outer leg with blood flowing at a steady rate, applied pressure for 20 minutes to control the bleeding", " skin tear measures 6 cm (centimeters) long to the top section of the skin tear, 5.5cm x 0.5cm to the center section of the skin tear, 2.8cm x 0.7 cm to the bottom section of the skin tear with dark blue colored bruising surrounding the entire skin tear, skin tear noted in the sharp of a 3 (inch) fishing lure." The documentation indicated the wound was cleansed and dressed and that the w/c was " padded securely for protection of fragile skin. "</p> <p>On 3/13/12 at 10:46 AM Resident #23 was observed sitting in her wheelchair. Her left leg had a wound dressing on it. There was no padding observed on the wheelchair at the location where the leg rests would attach.</p> <p>On 3/14/12 at 4 PM NA # 4 was interviewed and stated that on 2/24/12 she had gone in Resident #23 ' s room and observed her attempting to get out of bed on her own. She stated that she then assisted Resident #23 to transfer to the wheelchair but did not use the gait belt as Resident #23 was about to fall. NA # 4 revealed that during this transfer, Resident #23 sustained a skin tear. She also said that she was aware the resident had previously sustained a similar skin tear injury during transfer into the wheelchair. NA # 4 added that on 2/24/12 the wheelchair had not been padded at the area where the leg rests would attach.</p> <p>On 3/14/12 at 5:30 PM Resident #23 was observed sitting in her wheelchair. It was also</p>	F 323			

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F 323	Continued From page 13 observed that there was no padding on the wheelchair where the leg rests would attach. On 3/14/12 at 5:30 PN interview with Resident #23 revealed she recalled the incident where she received the skin tear that was on left lower leg. When she was asked how the injury occurred she pointed at the piece of metal jutting out from where the leg rests would normally attach to her chair and said that her leg had gotten cut on it. When asked if it had been painful she stated " it really hurt and they never fixed my wheelchair. " On 3/15/12 at 10 AM Administrative Staff # 3 and Administrative Staff #1 were interviewed. Both indicated that after the first skin tear injury, interventions should have been in place to prevent further injury from the same cause.	F 323			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425	F-425 See attached POC	4/12/12	

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F 425	<p>Continued From page 14 services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation and staff interview, the facility failed to date an opened medication (Advair Diskus) for one (1) of three (3) medication carts (E/F hall). The findings include:</p> <p>The facility's policy on " Medications with special storage and expiration dating requirements "(undated) was reviewed. The policy stated that Advair Diskus (used for people with Asthma and COPD (Chronic Obstructive Pulmonary Disease) "should be discarded 30 days after opening".</p> <p>The manufacturer's instruction written on the wrapper of the Advair Diskus read "Discard the diskus one month after removal from the overwrap. Fill in the dates on the diskus appropriately".</p> <p>An observation on 3/14/2012 at 5:10 PM., one Advair diskus was noted with fifty-three (53) doses left in the diskus. The pharmacy had dispensed the medication on February 14, 2012. There was no date that indicated when the medication was opened.</p> <p>On 3/14/2012 at 5:14 PM., Nurse Supervisor #2 stated she did not know if the medication should be dated. She further stated she thought the medication was good for sixty (60) days after opening but she was not sure.</p>	F 425		

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F 425	Continued From page 15 On 3/14/2012 at 5:14 PM., Administrative staff #1 stated the date the Advair diskus was opened should have been documented on the medication.	F 425			

PLAN OF CORRECTION TAG 483.20

F – 281

For resident affected

Affected resident is no longer a resident at this facility. Resident was discharged to home on 03/13/2012 in satisfactory condition and MD discontinued Clonidine order when resident was discharged to home.

For residents that have potential to be affected

All residents that have PRN blood pressure medications with similar parameters were checked with no concerns identified.

System Changes

On March 16, 2012 all residents with similar orders were inputted into our electronic medication administration records so they would flag the nurse when not administered, as well as print on the exception reports at the end of the medication pass which alerts the nurse when a medication has not been given. Additionally, on April 2, 2012 buttons were added to the electronic medical records to set reminders to alert the nurse when parameters trigger the PRN medication to be given. All nurses will be in-serviced on how to electronically input blood pressure orders with parameters so they are alerted when medication is not given per order as well as how to set reminders for staff when prn is needed to improve communication. All newly hired nurses and medication aides will be receiving training during the orientation period.

Measures put in place or systemic changes made

Effective March 20, 2012, a quality-assurance plan was implemented under the supervision of the Director of Nursing to ensure that the intervention is assessed for effectiveness. The Director of Nursing or designee will monitor each resident that has a PRN blood pressure medication with parameters weekly for one month to ensure that interventions are effective. Each resident will then be monitored monthly for one quarter, then quarterly for the remainder of the year. Results will be documented using the Quality Improvement Collection Form.

Monitoring plan to ensure solutions are sustained

The plan will be reviewed quarterly for one year at the facility QA&A meetings to ensure ongoing compliance

The corrective action will be completed by April 12, 2012

PLAN OF CORRECTION TAG 483.25

F-315

For the residents affected

A leg strap was immediately applied. Staff was educated on use of a leg strap per facility policy.

For residents that have potential to be affected

Because all residents with urinary catheters have the potential to be affected, on March 13, 2012, all residents in the facility with urinary catheters were provided with a leg strap to ensure that the catheters remain secured and to reduce friction and movement at the insertion site.

System Changes

Nursing staff will be in-serviced to emphasize importance of following the facility's policy to ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. The facility will attach a leg strap to catheter supplies to facilitate use of strap.

Monitoring plan to ensure solutions are sustained

The Staff Development Coordinator or designee will audit all residents with urinary catheters weekly for one month to ensure that they are secured with a leg strap per facility policy. All residents with urinary catheters will be audited monthly for one quarter, then quarterly for the remainder of the year. Findings will be recorded and corrected on the spot if indicated. The facility will provide additional in-services as necessary. The plan will be reviewed quarterly for one year at the facility QA&A meetings to ensure ongoing compliance

The corrective action will be completed by April 12, 2012

PLAN OF CORRECTION TAG # 483.25

F – 322

It is the Lutheran Home's expectation that care is provided for residents to assure they attain the highest possible well being.

For the resident affected

Resident # 24 respiratory status was monitored closely with normal breathing pattern noted. The resident remained afebrile with no changes in respiratory status. Licensed nurses medication aides and nursing assistants providing care were in-serviced to assure tube feeding is paused when the head of bed is lowered while care is being rendered, as soon as administrative nurses were made aware.

For residents that have the potential to be affected

At the present time, no other residents have naso-gastric or gastostomy tubes so no other resident has the potential to be affected. All nursing staff received mandatory in-service training on facility policy and procedures for tube feeding.

System Change

"Elevate head of bed 30 degrees or more for residents who receive tube feeding" has been added to the nursing assistants assignment sheets. Additionally, The Enteral Tube Feeding Policy was revised on 4/5/2012 to read, "head of the bed may be lowered and enteral feedings may be held for short periods of time in order to provide care".

Measures put in place or systemic changes made

Effective April 04, 2012, the Director of Nursing or designee will monitor for compliance of enteral policy and procedures weekly for 3 months then proceed to routine rounds. Results will be documented using the Quality Improvement Data Collection Form. Any areas of concern will be addressed on the spot.

Monitoring plan to ensure solutions are sustained

The plan will be reviewed quarterly for one year at the facility QA&A meetings to ensure ongoing compliance.

The corrective action will be completed by April 12, 2012

PLAN OF CORRECTION TAG # 483.25

F – 323

It is the Lutheran Home's expectation that our residents' environment remain as free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents.

For resident affected

The wheelchair was padded again. In addition to padding the wheelchair an order has been placed on the resident's medication administration record for the nurse to monitor wheelchair every shift and initial when checked to ensure that wheelchair is padded appropriately to prevent further skin tears.

For residents that have potential to be affected

Because all residents have the potential to be affected, all nurses and Certified Nursing Assistants will receive in-service training conducted by the DON or designee with emphasis on ensuring interventions remain in place in order to prevent recurrences of injuries. The interdisciplinary care plan team will check all resident's care plan to ensure that interventions are in place and maintained as necessary.

System Changes

Orders for wheelchair padding have been placed on the residents' medication administration record for the nurse to monitor and initial off on when checked to assure padding is on at all times.

All newly hired CNAs and nurses will receive in-service training regarding requirements for the facility to provide care in accordance with the comprehensive assessment and plan of care, as well as facility's expectations during orientation.

Measures put in place or systemic changes made

Effective April 04, The Assistant Director of Nursing will randomly select five charts weekly for one month to ensure interventions are in place to meet the needs of the residents. Three charts will be selected monthly for one quarter, then quarterly for the remainder of the year. Results will be documented using the Quality Improvement Data Collection Form. Any areas of concern will be addressed on the spot.

Monitoring plan to ensure solutions are sustained

The plan will be reviewed quarterly for one year at the facility QA&A meetings to ensure ongoing compliance with changes made as necessary.

The corrective action will be completed by April 12, 2012

PLAN OF CORRECTION TAG # 483.60

F – 425

For the resident affected

Advair Diskus was sent back to the pharmacy and reordered. Nurse on duty in-serviced on proper storage and expiration dating requirements for Advair Diskus.

For residents that have potential to be affected

All medication carts were checked to ensure all medications met the expiration dating requirements. All medication aides and nurses will be in-serviced by the DON/designee on special storage requirements and expiration dating requirements per facility policy.

System Change

The pharmacy will affix a bright yellow sticker reminder on the outside of all medications requiring a date opened to visually cue nursing staff of special requirements for dating. The pharmacy consultant or designee will inspect the medication carts monthly to ensure that the facility meets storage and dating requirements of medications administered. Any issues related to expiration dating requirements will be corrected immediately. All newly hired medication aides and nurses will receive training on medication storage and expiration dating requirements per facility policy during orientation.

Monitoring plan to ensure solutions are sustained

The DON or designee will audit each medication cart weekly for one month to ensure storage and expiration dating requirements are met. Results will be documented using the Quality Improvement Data Collection Form. Any areas of concern will be addressed on the spot.

The DON or designee will conduct random audits periodically and will report results to the Quality Assessment and Assurance meeting quarterly for up to a year with changes made as necessary to assure substantial compliance is maintained.

The corrective action will be completed by April 12, 2012

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NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME-ALBEMARLE	STREET ADDRESS, CITY, STATE, ZIP CODE 24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001
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K 000 INITIAL COMMENTS

K 000

This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. Both buildings are Type II protected construction, one story, without a complete automatic sprinkler system.

The deficiencies determined during the survey are as follows:

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 029

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
42 CFR 483.70(a)
By observation on 4/10/12 at approximately noon the following hazardous areas were non-compliant, specific findings include:

A. The E & F wing men's toilet was used for the storage of clean linen.

B. The closure to the activities room had been

The clean linen cart was removed from this room on 4/10/12

The door closure was re-installed on 4/11/12

RECEIVED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Shoula Trust Administrator

4/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 removed.	K 029			
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	Lefler Electronics inspected the Fire Alarm System on 4/11/12		
	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/10/12 at approximately noon the following fire alarm component was non-compliant, specific findings include: A. The annual fire system certification was conducted on 7/13/10				

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K 051	Continued From page 2	K 051			
K 067 SS=D	B. The fire alarm system was not on a dedicated circuit. The existing directory list and by testing confirm both the fire alarm system and duct detectors were on the same circuit. NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/10/12 at approximately noon the following Heating, Ventilating, and Air Conditioning (HVAC) item was non-compliant, specific findings include, the A hall smoke damper was in the closed position before and during fire alarm activation.	K 067	Ashley Hudson Electrical separated the duct detectors from the alarm panel so that the alarm panel is now on its own breaker. This work was completed on 4/16/12 The smoke damper on A hall was replaced and the new one was tested on 4/16/12		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/10/12 at approximately noon the following NFPA 96 item was non-compliant, specific findings include, three out of four drip pans to the kitchen hood was missing.	K 069	Drip pans were re-installed on 4/20/12		